OFFICIAL-SENSITIVE

Meeting	**IPC Cell Discussion**
Date & Time	**22 December 2020 – 10:00-11:30**
In attendance:	[redacted] (Chair)/[redacted]

Meeting notes

[redacted] talked through the Rapid Review of literature for SARS-Covid-2 variant and the implications in Healthcare. The variant strain in predominantly circulating in the South East. ECDC published a threat assessment in December. The increase could be attributed to seasonal mixing. There is no indication of increased infection severity. We should be reinforcing IPC precautions already in place. Minutes of nerve tag on the 18th of December show moderate evidence of an increase in transmissibility.

[redacted] - When variants are discovered they are called 'variants under investigation'. Once investigated they are called 'variants of concern'.

[redacted] - Everything [redacted] has summarised is what has been discussed by PHE so far.

[redacted] - There seems to be a higher rate in the variant strain in under 60s.

[redacted] - data is based on 250 patients approximately so numbers are small but the majority are under 60s. However, this could be due to who has presented for testing there may be implications of transmissibility in children, but this is conjecture.

[redacted] - There are staff that are not happy working with Covid patients, as they are worried due to the new strain so clear messaging is needed.

[redacted] talked through the paper on estimating the importance of different routes of SARS-CoV-2 transmission in hospital settings. The predominant transmission, according to modelling is patient to patient and between patient and healthcare workers is less frequent. The paper reiterates that but adds new data supplemented by the Wave 2 data. The learning has not changed. The new consensus statement adds that if you are a nosocomial case, you are more likely to transmit than community acquired. Community cases or are more likely to be identified earlier. It reinforces the need to concentrate on patient to patient transmission. Patients wearing face masks should be mandatory unless there are clinical reasons. We should urge organisations to measure compliance have more rapid testing, ideally at the front door or a short turn-around time so patients can be placed appropriately. Patient movement should be limited.

[redacted] - We need to make face mask guidance clear for patients in other settings external to hospitals.

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[redacted] - We need to provide a change a face mask for patients during their stay as there have been reports of patients only having one mask for their stay we must work with the [redacted] teams, as there can be conflicting advice re patient flow.

[redacted] Raised the issue at a meeting with the [redacted] team. Steve Powis was keen to emphasise how we move patients around safely.

[redacted] - We do not have legislation on mandatory face mask wearing for patients so it may cause issues with some patient groups for example, unseen disabilities so guidance should be clear.

[redacted] - We should consider the question of cohorting impatient Contacts and the risk of positive patients transmitting.

[redacted] - This emphasises is the need for rapid testing.

[redacted] - The patient groups most likely to transmit are very unwell patients who will be unable to wear masks.

[redacted] - There is need for a strong recommendation for patient face masks in Scotland it has been suggested it should be documented patient if patients cannot wear masks.

[redacted] - There is an issue of shared patient areas for example toilets cleaning of these areas must be increased and we need to be mindful of patients with dementia wearing masks for example.

[redacted] - There is a challenge with managing quarantine bays. We need to be clear when masks should be worn, as there has been an assumption that patients would not have to wear masks in bed. Should staff have FFP3 masks in Covid wards?

[redacted] - For elderly patients, many are unable to comply with mask wearing most of the time. The ability to achieve a 2-metre distance between patients is difficult we should be mandating toilet cleaning after every patient use. It is not ideal to cohort patients with respiratory infections but with 90% capacity and some hospitals this is not achievable.

[redacted] - We should consider whether current guidance drives the movement of patients in hospital.

[redacted] - The title for the guidance may not be the best and we may need to consider changing it.

[redacted] - There are already local governance measures in place to drive the changes forward.

[redacted] - Most patients brought in by ambulance could be wearing masks. There is a concern that extra measures could cause further delays to ambulances outside hospitals.

[redacted] - Patient should wear masks. There is also the importance of role modelling by staff some staff are not wearing masks in the correct way, for example.

[redacted] - We are all agreed that face masks for patients and staff should be advised. Patients should be getting new masks every day. There is also the importance of rapid testing and limiting patient movement. There is a question of whether we need to change the level of PPE but there does not seem to be evidence that the level should change.

[redacted] - We are currently looking at whether the new variant has caused clusters to understand the transmission. We would be wary of using FFP 3 masks at the moment and should look at the evidence first.

[redacted] – It is difficult given the lack of evidence but should we consider going back to a Table 4 style approach of PPE for everyone until the evidence is generated.

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[redacted] - As patient and staff face mask wearing is not where it should be, we should not move to FFP 3 mask wearing. Cleaning measures should also be increased first.

[redacted] - There is minimal evidence of patient to staff transmission, apart from areas which are high aerosol generating. Therefore, we should not need FFP3 masks.

[redacted] - Staff may not have a lot of time to educate patients on mask wearing. We should consider whether this could be done centrally.

[redacted] - If we increase the use of FFP3 masks we need to consider stock availability, as this could put additional pressure on Trusts.

[redacted] - If we make a decision regarding FFP3 masks, we need to be clear on why and we should review if evidence changes.

[redacted] - Our understanding of aerosol transmission has changed. A precautionary approach to move to FFP3 masks whilst we are awaiting evidence should be advised.

[redacted] - We need to consider the issue of evidence showing we do not need FFP 3 masks, after taking a precautionary approach. How do we manage staff expectations in hospitals and care homes?

[redacted] - Some hospitals are already moving to FFP 3 masks. We need a clear review date in a week and a rapid review of staff testing positive to confirm whether it is caused by a lapse in the use of PPE.

[redacted] - They have been changes in the attack rate on wards and the speed of transmission. There have also been changes in the attack rate among staff in red wards where it has increased. We need to take a different approach.

[redacted] - It is important we consider where the current recommendations are being fully implemented.

[redacted] - we have seen generally good compliance with PPE so evidence should not be put on poor use of PPE.

[redacted] - Issues of increased transmission could also be to do with Estates.

[redacted] - We need to decide what evidence we are going to measure against and what intelligence we will use.

[redacted] - we should use nosocomial data against community prevalence and do investigations into incidents. If there is high staff anxiety about the new strain, should we consider using FFP 3 masks?

[redacted] - There will be pressure from organisations and bodies for more precautionary measures. The faith of staff in high intensity units is being lost. If there is a high-risk pathway, we should take precautionary measures. In Wales renewal teams are moving to using FFP 3 masks.

[redacted] - We need a clear rationale for the use of FFP 3 masks in different areas. There are other ways we can support staff.

[redacted] - Patients in high risk areas do you have symptoms, therefore FFP3 masks could be worn in these pathways.

[redacted] - As a proportion more staff and patients are showing symptoms.

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[redacted] - the consensus seems to be a more precautionary approach for high risk pathways.

[redacted] - we may need to get any changes signed off.

[redacted] - we need to consider issues with fit testing and staff being excluded from work when failing a fit test.

[redacted] - It seems we need a more forceful recommendation on mask wearing compliance first.

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